Maine Cancer Registry Abstract for Hospitals

Please submit complete form to:

Maine Cancer Registry
11 State House Station
Key Plaza, 4th Floor
Augusta, ME 04333-0011

Hospital Registrar/Reporter:

Hospital Name:

NOTE: **All items in bold are required by the Maine Cancer Registry**

PATIENT IDENTIFICATION

Patient Last Name | **First Name** | **Middle Name** | Prefix | Suffix

Maiden Name | Alias | **Social Security Number** — — | Medical Record Number

Address Supp (Additional Address Information – Current)

Address St (Number and Street – Current)

City (Current) | **State** | **Zip (Plus 4)** | County | Phone

PATIENT PERSONAL INFORMATION

Date of Birth | **Place of Birth** | Expiration Date | Autopsy | Death Loc | **Sex**

1 – Male
2 – Female
3 – Other
4 – Transsexual
9 – Unknown

Race1 **Span Origin**

Race2 **Race4**

Race3 **Race5**

Race1

01 – White	07 – Hawaiian	13 – Kampuchean (Cambodian)	25 – Polynesian, NOS	32 – New Guinean
02 – Black	08 – Korean			96 – Other Asian, Oriental, NOS
03 – Amer. Indian Aleut, Eskimo	09 – Asian Indian, Pakistani	14 – Thai	26 – Tahitian	
04 – Chinese	10 – Vietnamese	20 – Micronesian, NOS	27 – Samoan	97 – Pacific Islander, NOS
05 – Japanese	11 – Laotian	21 – Chamorran	28 – Tongan	98 – Other
06 – Filipino	12 – Hmong	22 – Guamanian, NOS	30 – Melanesian, NOS	
			31 – Fiji Islander	99 – Unknown

Race2-5
Same as Race1 with the addition of 88 – No further race documented

Spanish Origin
0 – Non Spanish
1 – Mexican
2 – Puerto Rican
3 – Cuban
4 – S/Cent. Amer (X Brazil)
5 – Other Spanish
6 – Spanish, NOS
7 – Spanish Surname Only
9 – Unknown

Spouse (Last Name) | Spouse (First Name)

Employer | State | Phone

Longest Occupation | **Longest Industry**

DIAGNOSIS IDENTIFICATION

Site | **Sequence** | **ICD-O-3 Histology/Behavior** | **ICD-0-2 Histology/Behavior (prior to 2001)**

Grade

1 – Well Diff
2 – Mod Diff
4 – Undiff
5 – T-Cell
7 – Null Cell
8 – NK Cell

Laterality

0 – Not a Paired Site
1 – Right
3 – Only One Invol, R/L Unspec
4 – Bilateral Invol, Lat OriginUnk

3 – Poorly Diff 6 – B-Cell 9 – Not Determined 2 – Left 9 – Paired Site, Lat Unk; Midline

Pt Last Name: Pt First Name: SSN:

DIAGNOSIS IDENTIFICATION (Cont.)

Diagnostic Confirmation

1 – Positive histology
2 – Positive cytology, No pos histology
4 – Pos micro cnfrm, NOS
5 – Pos lab test/marker
6 – Dir visual w/o micro cnfrm
7 – Radiography w/o micro cnfrm
8 – Clinical diag only (other than 5, 6, 7)
9 – Unknown whether micro cnfrm

Reporting Source

1 – Hospital I/O, clinic
3 – Laboratory only
4 – Phys office/private med pract
5 – Nursing/Convalescent/Hospice
6 – Autopsy Only
7 – Death Certificate Only

Class of Case

0 – Dx Rpt Fac & all 1st Crs Trt Elsewhere
1 – Dx Rpt Fac & all /Part 1st Crs Trt at Rpt Fac
2 – Dx Elsw & All/Part 1s Crs Trt at Rpt Fac
3 – Dx & all 1st Crs Trt Elsewhere
4 – Dx &/or 1st Crs Trt Perf Rpt Fac Prior Ref Date
5 – 1st Dx at Autopsy
6 – Dx & all 1st Trt in same staff MD office
7 – Path Rpt Only/Pt never enters Rpt Fac for Dx/Trt
8 – Dx By Death Certificate Only
9 - Unknown

Date of 1st Contact | **Initial Dx Date** | 1st Positive Bx Date | Admission Date | Discharge Date

Primary Payer

01 – Not Insured, NOS
02 – Not Insured, Self-Pay
10 – Insurance, NOS
20 – Managed Care, HMO, PPO
31 – Medicaid
35 – Medicaid ADM By Managed Care
36 – Medicaid W Medicare Supplemt
50 – Medicare
51 – Medicare W Supplement
52 – Medicare W Medicaid Supp
53 – TRICARE
54 - Military
55 – Veterans Affairs
56 – Indian/Public Health Service
99 – Insurance Status Unknown

Family History
0 – No
1 – Yes
9 - Unknown

Tobacco Hx
0 – Never Used
1 – Cigarette Smoker, Current
2 – Cigar/Pipe Smoker, Current
3 – Snuff/Chew/Smokeless, Current
4 – Combo Use, Current
5 – Previous Use
9 – Unknown

Marital Status
1 – Single
2 – Married
3 – Separated
4 – Divorced
5 – Widow
9 - Unknown

Alcohol Hx
0 – No History Alcohol Use
1 – Current Use of Alcohol
2 – Past History of Alcohol Use
9 – Alcohol Usage Unknown

DIAGNOSIS EXTENT OF DISEASE

FOR CASES DIAGNOSED ON OR AFTER 01/01/2004: **Collaborative Staging fields (all fields within the CS Input area) must be coded using the Collaborative Staging Manual and Coding Instructions, version 1.0.**

CS Input:

CS Version | **Tumor Size** | **Extension** | **Size/Ext Eval**

Reg Nodes Examined | **Reg Nodes Positive** | **Lymph Nodes** | **Reg Nodes Eval**

Mets at Dx | **Mets Eval**

SS Factors 1 | 2 | 3 | 4 | 5 | 6

FOR CASES DIAGNOSED PRIOR TO 01/01/2004: **AJCC TNM Stage and General Summary Stage are required.**

AJCC Ed | **Reg Nodes Examined** | **Reg Nodes Positive** | **Gen Sum Stg**

	T	N	M	Stage	Descriptor
Path					
Clin					

Distant Sites 1 2 3

0 – None
1 – Peritoneum
2 – Lung
3 – Pleura
4 – Liver
5 – Bone
6 – CNS
7 – Skin
8 – Lymph Nodes (Distant)
9 – Other, Generalized, carcinomatosis, disseminated, Unk

Pediatric System | Stage | Staged By

Pt Last Name: Pt First Name: SSN:

DIAGNOSIS TREATMENT (Cont.)

Date 1st Crs Treatment
|_|_|_|_|_|_|_|_|

If no treatment was given, please use the date that this decision was made or the date of diagnosis.

Noncancer-Directed Surgery: ☐Yes ☐No ☐Unknown

Non Cancer Directed Surgery Code _____ Date Performed (mm/dd/yyyy) _____

Text: _____

_____

Cancer Directed Surgery (1): ☐ Yes ☐ No ☐ Unknown Reason No Surgery Code _____

Cancer Directed Surgery Code _____ Date Performed (mm/dd/yyyy) _____

Text: _____

_____

Cancer Directed Surgery (2): ☐ Yes ☐ No ☐ Unknown Reason No Surgery Code _____

Cancer Directed Surgery Code _____ Date Performed (mm/dd/yyyy) _____

Text: _____

_____

Radiation Therapy: ☐ Yes ☐ No ☐ Unknown Reason No Radiation Code _____ Surgery/Radiation Sequence _____

Radiation Therapy Code _____ Date Performed (mm/dd/yyyy) _____

Text: _____

_____

Chemotherapy: ☐ Yes ☐ No ☐ Unknown Reason No Chemotherapy Code _____

Chemotherapy Code _____ Date Performed (mm/dd/yyyy) _____

Text: _____

_____

Hormone Therapy: ☐ Yes ☐ No ☐ Unknown Reason No Hormone Code _____

Hormone Therapy Code _____ Date Performed (mm/dd/yyyy) _____

Text: _____

_____

Biological Response Modifier: ☐ Yes ☐ No ☐ Unknown Reason No BRM Code _____

BRM Code _____ Date Performed (mm/dd/yyyy) _____

Text: _____

_____

Hematological Transplant & Endocrine Procedure: ☐ Yes ☐ No ☐ Unknown Reason No H/E Code _____

H/E Code _____ Date Performed (mm/dd/yyyy) _____

Text: _____

_____

Other Treatment: ☐ Yes ☐ No ☐ Unknown

Other Code _____ Date Performed (mm/dd/yyyy) _____

Pt Last Name: Pt First Name: ____ SSN:

DIAGNOSIS MISCELLANEOUS DATA

License Number Name
Surgeon (N)

License Number Name
Fol Alternate 2 (2)

Managing (M)

Physician #3 (3)

Referring (R)

Physician #4 (4)

Following (F)

Facility Referred From Name/City

Facility Referred To Name/City

PATIENT STATUS

Next Follow-up Date **Date Last Contact**

Cancer Status
1 – No Evidence of This Cancer
2 – Evidence of This Cancer
9 – Unknown Whether This Cancer Present

Vital Status
0 – Alive
1 - Dead

Cause of Death (ICD)
Use ICD-O if cancer-related
Use ICD-9 for all other if available, otherwise use:
0000 – Pt Alive at Last Contact
7777 – State Death Certificate N/A
7797 – State Death Certificate Available

ICD Revision
0 – Pt Alive at Last Follow-Up
1 – ICD-10
7 – ICD-7
8 – ICD-8
9 – ICD-9

Cause of Expiration
D – Directly
I – Indirectly
N – Not Caused by Cancer
U – Unknown

RESIDENCE AT DIAGNOSIS (Use physical street addresses whenever available)

Address-Supp **Address-St**

City **State** **Zip** **County**

ABSTRACTING INFORMATION

Data Entry Initials Abstractor Initials

Pt Last Name: Pt First Name: SSN:

QA TEXT FIELDS

Diagnosis

PE (4 lines, 200 bytes)

Xray/Scan (5 lines, 250 bytes)

Scopes (5 lines, 250 bytes)

Lab Tests (5 lines, 250 bytes)

OP (5 lines, 250 bytes)

Path (5 lines, 250 bytes)

Prim Site Title (1 line, 40 bytes)

Hist Title (1 line, 40 bytes)

Staging (6 lines, 300 bytes)

Miscellaneous

Remarks (7 lines, 350 bytes)

Occupation (1 line, 40 bytes)

Industry (1 line, 40 bytes)

Place of Diagnosis (1 line, 50 bytes)

General Notes (42 lines, 2100 bytes)